

**Texas Health and Human Services Commission
Vendor Information Form (VIF)**

Instructions: This form must be completed and submitted with each new contract, amendment, renewal, and/or extension.
(Please type or print information.)


SECTION 1: Contractor's General Information

Legal Contractor's Name:	<u>Women's Health Care Center, Inc</u>		
Legal Doing Business As (DBA) Name:	<u>Women's Health Care Center, Inc</u>		
Physical Address:	<u>2914 S BUCKNER STE B DALLAS TEXAS 75227</u>		
Remit To (Payment) Address:	<u>2914 S BUCKNER STE B DALLAS TEXAS 75227</u>		
Enter Texas Identification Number (TIN)	Texas Identification Number (TIN): <u>-943432832</u> (11 digit TIN must be provided) (Contact Accounts Payable at Vendor@hhsc.state.tx.us for valid 11 digit TIN (if unknown))		
Select the Legal Status:	<input type="checkbox"/> For-profit Entity <input checked="" type="checkbox"/> Non-profit Entity		
Select the Business Structure:	<input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> Partnership* <input type="checkbox"/> Limited (Liability) Company <input type="checkbox"/> Limited (Liability) Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Governmental Entity (must specify): _____ <input type="checkbox"/> Other (must specify): _____ * If Partnership, must provide SSN or TIN for minimum of two partners		
	Partner Name: _____		TIN: _____
	Partner Name: _____		TIN: _____
If applicable, enter appropriate information:	State of Incorporation: <u>TEXAS</u>	Texas Charter Number: _____	Name of Parent Entity: _____


SECTION 2: Contractor's Contact Information

Person Who Will Sign the Contract		Point of Contact for Contract	
Name:	<u>SHERRY TENISON</u>	Name:	<u>SHERRY TENISON</u>
Title:	<u>EXECUTIVE OFFICE</u>	Title:	<u>EXECUTIVE DIRECTOR</u>
Mailing Address:	<u>2914 S BUCKNER</u>	Mailing Address:	<u>2914 S BUCKNER STE B</u>
Telephone:	<u>214-275-5256</u>	Telephone:	<u>214-275-5256</u>
Fax:	<u>214-275-5284</u>	Fax:	<u>214-275-5284</u>
E-mail:	<u>SHERRYTENISON@YAHOO.COM</u>	E-mail:	<u>SHERRYTENISON@YAHOO.COM</u>

SECTION 3: Contractor's Authorized Signature (or HHSC Contract Manager)

Printed Name	Signature	Date	Phone Number
SHERRY TENISON		8/1/2016	214-703-6527

SECTION 4: ECPS Contract and Administration Office Use Only

Contractor to Receive Payment:	<input type="checkbox"/> No <input type="checkbox"/> Yes	<i>Revised</i> 
Contract Number:		

FORM I: FAMILY PLANNING PROGRAM CLINIC SITES

Legal Business Name: Women's Health Care Center, INC Clinic Site # 1 of 1

CLINIC SITE INFORMATION: Complete this form for **EACH** clinic site that will provide Family Planning Program services funded under this enrollment.

Clinic Name: Women's Health Care Center, INC			
Street Address: 2914 S Buckner		Suite: B	
City: Dallas	County: Texas	Zip Code: 75227	HHSR: 3
Clinic APPOINTMENT Phone #: 214-275-5256		<i>Revised</i>	
Clinic PRIMARY Phone #: 214-275-5256		Fax: 214-275-5284	
Service Area (counties to be served by this clinic site): Dallas			
Contact Person: Sherry Tenison			
Pharmacy License #:	Class:	Date of Pharmacy License Application Submission: 6-24-16	
TPI#: 156721606		NPI #: 1265462865	
Date of Medicaid Application Submission (if no TPI# or NPI#):			
Subcontractor Site: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Mobile Site: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

CLINIC HOURS

DAY	HOURS OF OPERATION					
	Morning		Afternoon		Evening (after 5pm)	
	From	To	From	To	From	To
MONDAY	9	1	2	5		
TUESDAY	9	1	2	5		
WEDNESDAY	9	1	2	5		
THURSDAY	9	1	2	5		
FRIDAY	9	1	2	5		
SATURDAY	9	12				
SUNDAY	Closed					

TEXAS MEDICAL BOARD
 CERTIFICATION CARD
 LICENSE PERMIT NUMBER
 D9336
 EXPIRATION DATE
 05/31/2018
 BERNARD FRANK EDAMI, MD
 2225 PEGGY LN
 GARLAND TX 75042-5708
 PHYSICIAN FULL PERMIT

TEXAS MEDICAL BOARD
 P.O. BOX 2025 • AUSTIN, TEXAS 78768-2025
 PHYSICIAN FULL PERMIT
 LICENSE PERMIT NUMBER
 D9336
 EXPIRATION DATE
 05/31/2018
 BERNARD FRANK EDAMI, MD
 2225 PEGGY LN
 GARLAND TX 75042-5708
 THIS CERTIFIES THAT THE LICENSEE PERMIT HOLDER NAMED AND NUMBERED HEREON HAS PROVIDED THIS BOARD
 THE INFORMATION REQUIRED AND HAS PAID THE FEE FOR REGISTRATION FOR THE PERIOD INDICATED ABOVE
 PLEASE KEEP THIS BOARD NOTIFIED OF CHANGE OF ADDRESS

TEXAS MEDICAL BOARD

P.O. BOX 2020 • AUSTIN, TEXAS 78768-2020

PHYSICIAN FULL PERMIT

LICENSE/PERMIT NUMBER

D9338

BERNARD FRANK ADAMI, MD

2225 PEGGY LN

GARLAND TX 75042-5708

EXPIRATION DATE

05/31/2018

THIS CERTIFIES THAT THE LICENSEE/PERMIT HOLDER NAMED AND NUMBERED HEREON HAS PROVIDED THIS BOARD THE INFORMATION REQUIRED AND HAS PAID THE FEE FOR REGISTRATION FOR THE PERIOD INDICATED ABOVE
PLEASE KEEP THIS BOARD NOTIFIED OF CHANGE OF ADDRESS

TEXAS MEDICAL BOARD

IDENTIFICATION CARD

LICENSE/PERMIT NUMBER

D9338

BERNARD FRANK ADAMI, MD

2225 PEGGY LN

GARLAND TX 75042-5708

PHYSICIAN FULL PERMIT

FORM A: FACE PAGE

*This form requests basic information about the Applicant and project, including the signature of the authorized representative.
The face page must be completed in its entirety.*

APPLICANT INFORMATION

1) **LEGAL BUSINESS NAME:** WOMEN'S HEALTH CARE CENTER, INC.

2) **MAILING Address Information** (include mailing address, street, city, county, state and zip code):
2914 S BUCKNER STE B DALLAS TEXAS 75227

3) **PAYEE Name and Mailing Address** (if different from above):

4) **DUNS Number** (9-digit): 829195259

5) **Health and Human Service Region:**

6) **Federal Tax ID No.** (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) or
Social Security Number (9 digit): 943432832

**The Applicant acknowledges, understands and agrees that the Applicant's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.*

7) **TYPE OF ENTITY** (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> City | <input checked="" type="checkbox"/> Nonprofit Organization* | <input type="checkbox"/> Individual |
| <input type="checkbox"/> County | <input type="checkbox"/> For Profit Organization* | <input type="checkbox"/> Federally Qualified Health Centers |
| <input type="checkbox"/> Other Political Subdivision | <input type="checkbox"/> HUB Certified | <input type="checkbox"/> State Controlled Institution of Higher Learning |
| <input type="checkbox"/> State Agency | <input type="checkbox"/> Community-Based Organization | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Indian Tribe | <input type="checkbox"/> Minority Organization | <input type="checkbox"/> Private |
| | <input type="checkbox"/> Faith Based (Nonprofit Org) | <input type="checkbox"/> Other (specify): |

**If incorporated, provide 10-digit charter number assigned by Secretary of State:* 0800987809

8) **BUDGET PERIOD:** Start Date: July 1, 2016 End Date: August 31, 2017

9) **COUNTIES SERVED BY FAMILY PLANNING PROJECT:** (complete Form C: Texas Counties and Regions) DALLAS

10) **PRIMARY PLACE OF SERVICES PROVIDED** 2914 S BUCKNER STE B DALLAS TEXAS 75227

11) **TOTAL FUNDING REQUESTED:** 300,000

Fee for Service: \$300,000

Categorical: 0

12) **PROJECTED EXPENDITURES**

Does Applicant's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for Applicant's current fiscal year (excluding amount requested in line 9 above)? **

Yes No X

***Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.*

13) **FAMILY PLANNING (FP) PRIMARY CONTACT PERSON**

Name: SHERRY TENISON RN, EXECUTIVE DIRECTOR
Phone: 214-275-5256
Fax: 214-275-5284
Email: SHERRYTENISON@YAHOO.COM

14) **FINANCIAL OFFICER**

Name:
Donnie
Graham
Phone 214
Fax: 214-
275-
5284
Email: Do
nnie
Graham
@

The facts affirmed by me in this proposal are truthful and I warrant the Applicant is in compliance with the assurances and certifications contained in **APPENDIX I: HHSC Assurances and Certifications**. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the Applicant and I (the person signing below) am authorized to represent the Applicant.

15) **AUTHORIZED REPRESENTATIVE**

Name: Sherry Tenison RN Executive Director
Title: Executive Director

16) **SIGNATURE OF AUTHORIZED REPRESENTATIVE**

17) **DATE**

8/1/2016

Revised

Phone: 214-275-5256
Fax: 214-275-5284
Email: sherryt@son@vahoo.com

8-1-2016

Revised

